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Medicare+Choice Plan Disenrollment Form

This is a request to disenroll from a Medicare+Choice plan.

(Please print in black ink.)

I wish to disenroll from:

Medical plan *(Check one.)* ☐ Group Health Cooperative ☐ Kaiser Senior Advantage ☐ PacifiCare Secure Horizons	Effective date of change
Subscriber's name	
Subscriber's signature Retiree must sign printed copy to disenroll	Date
Medicare number	
Spouse/same-sex domestic partner's name	
Spouse/same-sex domestic partner's signature Spouse must sign printed copy to disenroll	Date
Medicare number	

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.pebb.hca.wa.gov

Please return this form to:

Washington State Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

Washington State Health Care Authority
Public Employees Benefits Board

HCA 51-556 (10/02)